Pediatric / Adolescent Patient Intake Form

Please complete fully so we can help your child best.

Patient Information

Child's Name: _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Age: _____ Birth Date: ____ /____ /____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____
Name of Parents/Guardians: _____
Parent's Home phone: _____ Work phone: _____ Cell phone: _____
Parent's Email: _____ Adolescent's Email: _____
Referred By: _____
Favorite Hobbies or Interests: _____

Consultation

Reason for seeking chiropractic care: _____
When did the problem begin: _____
Is this problem ___ Occasional ___ Frequent ___ Constant ___ Intermittent ___ Other _____
If the pain travels, where does it go? _____
What makes it better? _____
What makes it worse? _____
Is the problem worse during a certain time of the day? ☐Yes ☐No If yes, when? _____
Does this interfere with the child's: Sleep? ☐Yes ☐No Eating? ☐Yes ☐No Daily routine? ☐Yes ☐No
Is this becoming worse? ☐Yes ☐No If yes how?_____
Other professionals seen for this condition? _____
Results with treatment? _____
Do you have family members with similar health concerns? ☐Yes ☐No If yes, who?_____
Has he/she ever been diagnosed with cancer? ☐Yes ☐No If yes, what kind? _____
Known Allergies: _____

Prenatal History (for Infants and Newborns)

Is the child adopted? ☐Yes ☐No
Name of Obstetrician/Midwife _____
Complications during pregnancy: ☐Yes ☐No List: _____
Ultrasounds during pregnancy: ☐Yes ☐No If yes, how many? _____
Birth Intervention: Forceps Vacuum Caesarian: Planned or Emergency
Complications during delivery: ☐Yes ☐No If Yes, please state_____
Medications/drugs/caffeine during pregnancy: ☐Yes ☐No If yes, please list type and amount:
_____
Cigarette /Alcohol use during pregnancy: ☐Yes ☐No
Was the infant alert and responsive within 12 hours of delivery? ☐Yes ☐No
If No, please explain: _____
Birth Weight _____ Birth Length _____ APGAR scores _____
Genetic disorders or disabilities? _____
Breast Fed: ☐Yes ☐No How Long? _____ Formula Fed: ☐Yes ☐No How Long? _____
Solids at _____ months Cow's milk at _____ months Food/Juice allergies or intolerances: ☐Yes ☐No
At what age did the child: Respond to sound _____ Follow an object _____ Hold head up _____
Vocalize _____ Sit alone _____ Crawl _____ Walk _____ Sleep Through Night _____

History

Previous Chiropractor:_____ Date of last visit & Reason: _____
_____
Name of Pediatrician: _____ Date of last visit & Reason: _____
_____
Are you satisfied with the care your child received there? ☐Yes ☐No
Has your child been vaccinated? ☐Yes ☐No If yes, for what? _____
Has your child ever had any reactions to vaccinations? ☐Yes ☐No ☐ Not Sure
If YES or NOT SURE, please explain: _____
Please List:

	Medications	**For What Condition**	**Taken How Long**
Please list all medicines, OTC & Prescribed	1.		
	2.		
	3.		
	4.		
	5.		

Vitamins/Supplements/Herbs	**For What Condition**	**Taken How Long**
1.		
2.		
3.		
4.		
5.		

Number of antibiotics your child has taken: Past 6 months _____ Total during his/her lifetime _____
Number of hours your child sleeps? _____ hours per day Sleep Quality? ☐Good ☐Fair ☐Poor
How would you rate your child's diet: ☐Well-balanced ☐Average ☐High Sugar/Processed Foods
How many servings of *different* fruits/vegetables do they eat per day? _____

Check all that apply: (Specify Amounts)
☐ Drink Coffee _____ ☐ Drink Sweet Tea _____ ☐ Milk _____ ☐ Artificial Sweeteners _____
☐ Juice/Sports Drinks _____ ☐ Soft Drinks _____ ☐ Candy _____ ☐ Fluoridated/Tap Water _____

Learning Ability:
- ☐ My child does very well at school.
- ☐ My child struggles with some subjects but overall enjoys learning.
- ☐ My child has had difficulty getting their homework done and usually falls behind in their work.

Falls & Injuries

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc) Is this the case with your child? ☐Yes ☐No
When was your child's most recent fall? _____ What happened? _____
_____

Activity Level — Please check those that best describes your child:
☐ My child is extremely involved in competitive sports. *Please specify sport/activity _____
☐ My child is moderately active. He/She plays some sports or dances and enjoys outdoor activities almost daily
☐ My child is occasionally active. He/She may do things like ride their bike, swim, or toss the ball a few times/week
☐ My child is seldom active. The only activity he/she may get is in P.E. class
☐ My child does not participate in P.E. class on a regular basis

Which of the following sports has your child been involved in?

__ Football __ Basketball __ Soccer __ Gymnastics/Cheerleading __ Martial Arts
__ Running __ Horseback riding __ Other: _____

Has your child ever broken a bone? ☐Yes ☐No If yes, which one? _____
Has your child ever been involved in an auto accident? ☐Yes ☐No Was there impact? ☐Yes ☐No
Were there injuries? ☐Yes ☐No (Dates/any treatment) _____
Has your child ever been seen on an emergency basis? ☐Yes ☐No (please list all) _____
_____
Other traumas not described above? ☐Yes ☐No _____
Prior surgery: ☐Yes ☐No If yes, Type and Date: _____
Menses: ☐Yes ☐No Age: _____

Childhood Diseases & Illness

Please check if your child has had or is currently suffering from any of the following:

	Past	Present		Past	Present
Acid Reflux	☐	☐	Gas / Bloating	☐	☐
Acne	☐	☐	Growing Pains	☐	☐
ADD/ADHD	☐	☐	Headaches	☐	☐
Allergies	☐	☐	Heart Trouble	☐	☐
Anemia	☐	☐	Heartburn	☐	☐
Anorexia/Bulemia	☐	☐	Hemorrhoids	☐	☐
Arthritis	☐	☐	Hernias	☐	☐
Asthma	☐	☐	Hives / Itchy Skin	☐	☐
Autism	☐	☐	Hyperactivity	☐	☐
Backaches	☐	☐	Hypertension	☐	☐
Bed Wetting	☐	☐	Irregular Menstrual Cycle	☐	☐
Behavioral Problems	☐	☐	Jaundice	☐	☐
Bladder Troubles	☐	☐	Jaw Pain	☐	☐
Blood Disorders	☐	☐	Learning Challenges	☐	☐
Bloody Stools	☐	☐	Loss of Balance	☐	☐
Blurred Vision	☐	☐	Loss of Sleep	☐	☐
Breast Pain / Lumps	☐	☐	Loss of Smell	☐	☐
Broken Bones	☐	☐	Migraines	☐	☐
Bronchitis	☐	☐	Mumps	☐	☐
Car Accident	☐	☐	Nausea	☐	☐
Chest Pain	☐	☐	Neck Pains	☐	☐
Chicken Pox	☐	☐	Nervousness	☐	☐
Chronic Colds	☐	☐	Nutritional Deficiencies	☐	☐
Chronic Earaches	☐	☐	Poor Appetite	☐	☐
Cold Extremities	☐	☐	Poor Coordination	☐	☐
Colic	☐	☐	Recurring Fevers	☐	☐
Concussion	☐	☐	Rubella	☐	☐
Constipation	☐	☐	Scoliosis	☐	☐
Convulsions	☐	☐	Seizures	☐	☐
Cramps	☐	☐	Shortness of Breath	☐	☐
Dental Problems	☐	☐	Shoulder Pain	☐	☐
Depression	☐	☐	Sinus Infections	☐	☐
Diabetes	☐	☐	Skin Problems	☐	☐
Diarrhea	☐	☐	Socially Withdrawn	☐	☐
Difficulty Hearing	☐	☐	Sore Throats	☐	☐
Digestive Problems	☐	☐	Stomach Aches	☐	☐
Dizziness	☐	☐	Swelling in Ankles	☐	☐
Ear Infection	☐	☐	Temper Tantrums	☐	☐
Epilepsy	☐	☐	Unexplained Weight Loss	☐	☐
Excessive Appetite	☐	☐	Urinary Problems	☐	☐
Excessive Thirst	☐	☐	Walking Problems	☐	☐
Fainting	☐	☐	Whooping Cough	☐	☐
Fatigue	☐	☐			

Authorization To Treat A Minor

I _____, Parent or legal Guardian of _____
Your Name (Print) Child's Name

hereby authorize **Joseph M. Wardie, D.C.** and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parents is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____
Signature of Parent/Guardian Date

Do you have out-of-network chiropractic benefits through your health insurance plan? ☐ Yes ☐ No

Please Note: Our office is currently out-of-network with <u>all</u> insurance plans, therefore <u>all charges are due at time of service</u>. If you have out-of-network chiropractic benefits, we would be happy to provide you with a documented receipt of the services rendered by our office for you to submit to your insurance company for possible reimbursement.
